		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025619

Facility Name: Shawnee Christian Nursing Center

Address: 1901 North 13th - P O Box 680 (Number) Herrin (City) 62948-0680 (Zip Code)

County: Williamson

Telephone Number: 618-942-7391 **Fax #** ( )

IDPA ID Number: 37-0841562005

Date of Initial License for Current Owners: 09/01/1980

Type of Ownership:

[x]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[x]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501c3

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2003 to June 30, 2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Richard A. Walbert
(Title) Vice President of Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	159	Skilled (SNF)	159	58,035	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,035	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,157	11,493	6,678	43,328	8
9	SNF/PED					9
10	ICF	8,697	2,780		11,477	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,854	14,273	6,678	54,805	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.43%

D. How many bed-hold days during this year were paid by Public Aid? 571 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Noe

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 09/01/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 159 and days of care provided 6,678

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	227,152	18,897	12,705	258,754		258,754		258,754			1
2	Food Purchase		222,297		222,297		222,297	(4,056)	218,241			2
3	Housekeeping	216,990	20,823		237,813		237,813		237,813			3
4	Laundry											4
5	Heat and Other Utilities			123,806	123,806		123,806	11,642	135,448			5
6	Maintenance	44,000	33,151	18,305	95,456		95,456	12,652	108,108			6
7	Other (specify):*											7
8	**TOTAL General Services**	488,142	295,168	154,816	938,126		938,126	20,238	958,364			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,888,300	306,102	11,376	2,205,778		2,205,778		2,205,778			10
10a	Therapy			421,924	421,924		421,924		421,924			10a
11	Activities	27,832			27,832		27,832		27,832			11
12	Social Services	109,373	1,799	5,088	116,260		116,260	(27)	116,233			12
13	Nurse Aide Training											13
14	Program Transportation			1,987	1,987		1,987	(1,987)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,025,505	307,901	445,875	2,779,281		2,779,281	(2,014)	2,777,267			16
	C. General Administration											
17	Administrative	82,548	1,928	323,664	408,140		408,140	(237,807)	170,333			17
18	Directors Fees											18
19	Professional Services			5,898	5,898		5,898	10,283	16,181			19
20	Dues, Fees, Subscriptions & Promotions			65,442	65,442		65,442	(28,270)	37,172			20
21	Clerical & General Office Expenses	85,262	6,554	117,333	209,149		209,149	50,777	259,926			21
22	Employee Benefits & Payroll Taxes			539,211	539,211		539,211	33,452	572,663			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,598	10,598		10,598	14,029	24,627			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			157,753	157,753		157,753	1,358	159,111			26
27	Other (specify):*											27
28	**TOTAL General Administration**	167,810	8,482	1,219,899	1,396,191		1,396,191	(156,178)	1,240,013			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,681,457	611,551	1,820,590	5,113,598		5,113,598	(137,954)	4,975,644			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shawnee Christian Nursing Center #0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			181,902	181,902		181,902	29,081	210,983			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			490,575	490,575		490,575	(3,167)	487,408			32
33	Real Estate Taxes			356	356		356		356			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Def Bond Costs			1,291	1,291		1,291		1,291			36
37	**TOTAL Ownership**			674,124	674,124		674,124	25,914	700,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			28,367	28,367		28,367		28,367			39
40	Barber and Beauty Shops	20,606	1,055		21,661		21,661		21,661			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,292	87,292		87,292		87,292			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	20,606	1,055	115,659	137,320		137,320		137,320			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,702,063	612,606	2,610,373	5,925,042		5,925,042	(112,040)	5,813,002			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,638	30		9
10	Interest and Other Investment Income	(8,348)	32		10
11	Discounts, Allowances, Rebates & Refunds	(392)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,453)	21		24
25	Fund Raising, Advertising and Promotional	(120)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(30,575)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,250)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,790)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (23,790)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (112,040)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Shawnee Christian Nursing Center

ID# 0025619

Report Period Beginning: July 1, 2003

Ending: June 30, 2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Exempt Interest Income - Endowment	$ 5,181	32	1
2	Loss on Disposal	(1,928)	21	2
3	Vending	(3,664)	2	3
4	Activity	(27)	12	4
5	Marekting	(28,150)	20	5
6	Transportation	(1,987)	14	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(30,575)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,056)	0	0	0	0	0	0	0	0	0	0	(4,056)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	11,642	0	0	0	0	0	0	0	0	0	11,642	5
6	Maintenance	0	12,652	0	0	0	0	0	0	0	0	0	12,652	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,056)	24,294	0	0	0	0	0	0	0	0	0	20,238	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(27)	0	0	0	0	0	0	0	0	0	0	(27)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,987)	0	0	0	0	0	0	0	0	0	0	(1,987)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,014)	0	0	0	0	0	0	0	0	0	0	(2,014)	16
	C. General Administration													
17	Administrative	0	(237,807)	0	0	0	0	0	0	0	0	0	(237,807)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,283	0	0	0	0	0	0	0	0	0	10,283	19
20	Fees, Subscriptions & Promotions	(28,270)	0	0	0	0	0	0	0	0	0	0	(28,270)	20
21	Clerical & General Office Expenses	(59,381)	110,158	0	0	0	0	0	0	0	0	0	50,777	21
22	Employee Benefits & Payroll Taxes	0	33,452	0	0	0	0	0	0	0	0	0	33,452	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,029	0	0	0	0	0	0	0	0	0	14,029	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,358	0	0	0	0	0	0	0	0	0	1,358	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(87,651)	(68,527)	0	0	0	0	0	0	0	0	0	(156,178)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(93,721)	(44,233)	0	0	0	0	0	0	0	0	0	(137,954)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,638	20,443	0	0	0	0	0	0	0	0	0	29,081	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,167)	0	0	0	0	0	0	0	0	0	0	(3,167)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,471	20,443	0	0	0	0	0	0	0	0	0	25,914	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(88,250)	(23,790)	0	0	0	0	0	0	0	0	0	(112,040)	45

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc	100.00%	$ 11,642	$ 11,642	1
2	V	6	Maintenance				12,652	12,652	2
3	V	17	Administrative	323,664			85,857	(237,807)	3
4	V	19	Professional Services				10,283	10,283	4
5	V	21	Clerical				110,158	110,158	5
6	V	22	Employee Benefits				33,452	33,452	6
7	V	24	Travel & Seminar				14,029	14,029	7
8	V	26	Insurance				1,358	1,358	8
9	V	30	Depreciation				20,443	20,443	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 323,664			$ 299,874	$ * (23,790)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: ne 30, 2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Herrin		x	Refinance Debt	$19,733.00	09/01/93	$ 2,720,000	$ 2,080,000	09/01/18	0.0700	$ 147,758	1
2	1996-A Bonds	x		Refinance Debt	$1,566.00	07/01/96	225,000	194,475	07/01/21	0.0700	13,751	2
3	1999-A Bonds	x		Refinance Debt	$7,161.00	01/01/99	1,000,000	899,400	01/01/24	0.0700	63,542	3
4	2001-Z Bonds	x		Refinance Debt	$18,666.00	10/01/01	3,200,000	3,200,000	10/01/31	0.0700	224,000	4
5												5
	Working Capital											
6	CHI Bond Fund	x		Refinance Debt							7,889	6
7	CHI Revolving Fund	x		Refinance Debt				84,281		0.0200	25,235	7
8	Financing Fee Amortization	x		Refinance Debt							8,400	8
9	TOTAL Facility Related				$47,126.00		$ 7,145,000	$ 6,458,156			$ 490,575	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,145,000	$ 6,458,156			$ 490,575	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Christian Nursing Center COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0025619

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-18-429-008	007 000 230 - W1S N75 408-138	$ 332.82	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 332.82	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,100 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	180,000	1980	$ 71,171	1
2	Home Office Allocation			8,846	2
3	TOTALS	180,000		$ 80,017	3

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	159		1980	1971	$ 1,666,025	$ 44,338	35	$ 47,601	$ 3,263	$ 1,056,938	4
5			1980	1980	107,504		20	5,375	5,375		5
6											6
7											7
8	Home Office Allocation				70,373	2,040		2,040		34,265	8
	Improvement Type**										
9	Storage Building			1981	6,510		20			6,510	9
10	Roof Repair			1981	3,660		5			3,660	10
11	Hearing & A/C System			1982	37,091		20			37,091	11
12	TV System			1982	9,873		15			9,873	12
13	TV System			1982	1,182		20			1,182	13
14	Building Improvements			1982	159,808	4,098	39	4,098		92,205	14
15	Building Improvements			1983	22,362	588	38	588		12,642	15
16	Roof Repair			1983	4,538		10			4,538	16
17	Smoke Alarm			1984	650	7	20	7		650	17
18	Building Improvements			1985	44,866	1,122	40	1,122		21,038	18
19	Roof Replacement			1985	192,604	459	35	459		99,513	19
20	Windows			1985	39,252	981	40	981		18,394	20
21	Ceiling Tile			1985	4,232	212	20	212		3,940	21
22	A/C System			1985	4,200		10			4,200	22
23	Light Fixtures			1985	777		10			777	23
24	Ceiling Tile			1986	1,874	94	20	94		1,653	24
25	Duct Work			1986	1,600	80	20	80		1,420	25
26	Building Improvements			1986	4,103		10			4,103	26
27	Wiring			1987	891	45	20	45		788	27
28	Dining & Adminstration Wing			1987	688,723	17,218	40	17,218		295,372	28
29	Remodeling			1987	705	35	20	35		592	29
30	Ceiling Duct			1987	510	26	20	26		440	30
31	Duct Work			1987	635	32	20	32		536	31
32	Energy System			1987	11,000		15			11,000	32
33	Remodeling			1988	552	28	20	28		457	33
34	Electrical Supply			1988	373	19	20	19		310	34
35	Air Cleaner & Duct			1988	1,694		10			1,694	35
36	Mirror			1988	1,562		10			1,562	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HVAC System	1988	$ 4,675	$ 234	20	$ 234	$	$ 3,783	37
38	Windows	1988	705	20	35	20		322	38
39	Baseboard	1988	739	37	20	37		595	39
40	Heat Pumps	1988	27,223	1,361	20	1,361		21,889	40
41	Floor Tile	1988	340		5			340	41
42	Duct Work	1988	22,066	1,103	20	1,103		17,464	42
43	Roof Work	1988	1,254		15			1,254	43
44	Towel & Soap Dispenser	1988	1,976		10			1,976	44
45	Title Policy	1988	3,740	94	40	94		1,488	45
46	Hampton Settlement	1988	74,000	1,850	40	1,850		29,292	46
47	Wall Heat Pump	1989	1,300		10			1,300	47
48	Flourescent Light	1989	673		10			673	48
49	A/C Electrical Work	1989	6,950		8			6,950	49
50	Heat Pumps/Duct System	1989	39,940	1,997	20	1,997		29,955	50
51	Down Spouts	1989	600	40	15	40		593	51
52	Laundry Room Roof	1989	2,200	147	15	147		2,180	52
53	Energy Management System	1989	5,692	347	20	347		5,558	53
54	Heat Pumps	1989	63,466	3,173	20	3,173		46,009	54
55	Wander Guard	1989	11,417	571	20	571		8,280	55
56	Air Conditioning	1989	5,820		8			5,820	56
57	Ceiling Tile	1989	1,868		10			1,868	57
58	Trimming (1200")	1990	840		5			840	58
59	Remodel Rooms	1990	2,446	122	20	122		1,769	59
60	Baseboard (120')	1990	706		5			706	60
61	Shelving	1990	851		5			851	61
62	Floor Tile	1990	426		5			426	62
63	Water Heater	1990	386	26	15	26		373	63
64	Smoke Detectors	1990	890		5			890	64
65	Flourescent Lights (20)	1990	775		10			775	65
66	Door & Hardware	1990	541		5			541	66
67	Wallpaper	1990	919		5			919	67
68	Relocate Sprinklers	1990	583		10			583	68
69	Brick A/C Holes	1990	1,352	34	40	34		482	69
70	TOTAL (lines 4 thru 69)		$ 3,377,088	$ 82,578		$ 91,216	$ 8,638	$ 1,924,087	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,377,088	$ 82,578		$ 91,216	$ 8,638	$ 1,924,087	1
2	Door Frames	1990	303		5			303	2
3	Paint & Wallpaper	1990	1,118		5			1,118	3
4	Heating Receivers (11)	1990	1,975	132	15	132		1,859	4
5	Kickplates	1990	763		10			763	5
6	Air Conditioner	1990	1,184		8			1,184	6
7	Door Alarm	1990	423		5			423	7
8	Doors & Lock	1990	35,817	1,791	20	1,791		24,925	8
9	Lights (13)	1990	590		10			590	9
10	Door Kickplates (118)	1990	2,104		10			2,104	10
11	Electrical Connection to Emergency Generator	1990	6,930	347	20	347		4,713	11
12	Remodeling	1991	2,733	137	20	137		1,850	12
13	Door Locks	1991	510	26	20	26		351	13
14	Floor Tile Install	1991	10,926		5			10,926	14
15	Cove Base	1991	1,763		10			1,763	15
16	Handrail, Drywall	1991	569		5			569	16
17	Exit Fixtures	1991	1,619		10			1,619	17
18	A/C Units (2)	1991	15,885		10			15,885	18
19	Wallcoverings	1991	483		5			483	19
20	Heat Pump	1991	5,267	351	15	351		4,504	20
21	Walk-in Freezer	1991	8,643	576	15	576		7,392	21
22	Water Heater	1991	867		10			867	22
23	Hall Lights	1992	2,091		10			2,091	23
24	Water Heaters	1992	3,164	211	15	211		2,620	24
25	Heat Pump	1992	653	44	15	44		546	25
26	Heat Pump	1992	7,265	484	15	484		5,848	26
27	4' Loop System	1992	3,723		10			3,723	27
28	Building Lighting	1992	1,142		10			1,142	28
29	Metal Door Frames	1992	840	42	20	42		500	29
30	Garbage Disposals	1994	2,072		5			2,072	30
31	Tub Room Remodel	1993	4,015		10			4,015	31
32	Building Remodeling	1993	6,103	305	20	305		3,370	32
33	Honeywell System	1993	5,031	252	20	252		2,793	33
34	TOTAL (lines 1 thru 33)		$ 3,513,659	$ 87,276		$ 95,914	$ 8,638	$ 2,036,998	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,513,659	$ 87,276		$ 95,914	$ 8,638	$ 2,036,998	1
2	Sink & Doors	1994	3,381	311	10	311		3,381	2
3	Roof Repair	1993	4,608	51	15	51		3,019	3
4	Storage Room Remodel	1994	2,020	101	20	101		1,061	4
5	Sewage Pump System	1994	4,256	315	10	315		4,256	5
6	Fire/Garage Door	1994	526		5			526	6
7	Handrails	1995	6,079	608	10	608		5,570	7
8	Remodeling (Side 1)	1995	7,992		5			7,992	8
9	Cabinets	1995	2,343	156	15	156		1,411	9
10	Therapy/Bath	1996	181,372	7,557	24	7,557		61,715	10
11	Fire Alarm System Relay	1996	2,596	260	10	260		2,058	11
12	Cnvt Tub Room/Quiet	1997	1,296		5			1,296	12
13	Water Fountain	1997	502		5			502	13
14	Roof Repairs	1997	534		5			534	14
15	Compressor	1997	973		3			973	15
16	Compressor Unit 1516	1997	2,377		3			2,377	16
17	Roof Work	1997	1,276		5			1,276	17
18	Remodeling (Side 2 & 3)	1997	38,878	2,592	15	2,592		13,392	18
19	Replace/Rewire Hot Water Heater	1998	9,445	945	10	945		5,985	19
20	Kitchen Heaters	1998	793		3			793	20
21	Compressor/Library #24	1999	2,972		3			2,972	21
22	Keyless locks	1999	1,423	46	5	46		1,423	22
23	Wallpaper dining room	1999	3,071	461	5	461		3,071	23
24	120 gal water heater	1999	3,000	300	10	300		1,525	24
25	Mixing valve water heater	2000	961	192	5	192		944	25
26	Compressor	2000	1,133		3			1,133	26
27	Security control system	2000	940	94	10	94		439	27
28	Remodel admin office/wiring	2000	1,147	229	5	229		984	28
29	Rooftop cond unit	2000	3,373	337	10	337		1,404	29
30	4 ton A/C	2000	2,590	518	5	518		2,115	30
31	4 ton hest pumps	2000	4,780	478	10	478		1,952	31
32	4 Ton Heat Pumps	2000	2,692	269	10	269		1,031	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,812,988	$ 103,096		$ 111,734	$ 8,638	$ 2,174,108	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,812,988	$ 103,096		$ 111,734	$ 8,638	$ 2,174,108	1
2	Remodel Rooms 18,20,22,24,37	2000	2,214	221	10	221		829	2
3	Remodel Rooms 9-17	2001	2,657	266	10	266		887	3
4	Install Grease Trap	2001	886	177	5	177		575	4
5	4 Person Booth Island (Bolted to Floor)	7/1/2001	593	59	10	59		177	5
6	(3) 4 Ton Heat Pumps	8/22/2001	7,985	799	10	799		2,330	6
7	Door Control System	1/1/2002	12,860	1,286	10	1,286		3,215	7
8	Countertop-Nursing Station Side 1	1/1/2002	750	50	15	50		125	8
9	Install Evap and Condenser in Walk-In Freezer	3/6/2002	3,685	921	4	921		2,149	9
10	Install Dishwasher	5/24/2002	1,100	110	10	110		238	10
11	Countertop-Nursing Station Side 2	3/22/2002	760	51	15	51		119	11
12	York Olympian Heat Pump	6/21/2002	2,265	227	10	227		473	12
13	3 Ton Olympian Heat Pump	7/3/2002	2,265	227	10	227		454	13
14	Nursing Station - Side #3	8/9/2002	1,146	76	15	76		146	14
15	7.5 Ton York Heat Pump - Dining Room	7/31/2002	8,750	875	10	875		1,750	15
16	Replacement Compressor in kitchen AC	8/31/2002	875	292	3	292		560	16
17	30 Position Nurse Call Station w/d	10/2/2002	1,100	110	10	110		193	17
18	(10) Panic Bars/(41)Door Knobs	12/9/2002	746	149	5	149		236	18
19	4 Ton York Heat Pump - Unit #1	1/8/2003	2,341	234	10	234		351	19
20	Remodel DON Office	2/11/2003	871	174	5	174		174	20
21	(12) Wall Signs w/Letters	2/27/2003	789	158	5	158		224	21
22	Nurse Call Light System - Side 1	8/1/2003	970	89	10	89		89	22
23	New Roof - Side 1	8/4/2003	52,263	2,613	15	2,613		2,613	23
24	Roof Replacement	8/4/2003	93,091	28,444	3	28,444		28,444	24
25	Replace Ceiling Panels/Kitchen & Side 1	10/23/2003	571	86	5	86		86	25
26	Remodel Business Office	2/16/2004	920	77	5	77		77	26
27	Elemco/Opto 22 Energy Management System	3/2/2004	18,962	632	10	632		632	27
28	Service Sink w/double pedal valves	6/3/2004	1,189	10	10	10		10	28
29	Heat Pump	6/16/2004	4,800	40	10	40		40	29
30	Carport	9/22/2000	1,363	136	10	136		521	30
31	Bus barn	3/1/2003	8,752	219	40	219		292	31
32	Fully depreciated land improvements	6/30/1982	62,437		15			62,437	32
33	Parking lot and sewer	2/29/1988	4,658	233	20	233		3,747	33
34	TOTAL (lines 1 thru 33)		$ 4,117,602	$ 142,137		$ 150,775	$ 8,638	$ 2,288,301	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,117,602	$ 142,137		$ 150,775	$ 8,638	$ 2,288,301	1
2	Courtyard walks and projects	9/30/1989	18,906	945	20	945		14,096	2
3	Fencing	6/8/1990	1,700	113	15	113		1,591	3
4	Landscaping, patio, wall & sidewalk	8/30/1990	18,837	942	20	942		13,079	4
5	Drainage, lanscaping & Gazebo	8/14/1991	12,452	622	20	622		7,987	5
6	100' Fence	12/5/1991	1,380	92	15	92		1,158	6
7	Landscaping, seeding, lighting & gazebo roof	6/8/1992	13,660	684	20	684		8,394	7
8	Sidewalk & fence	8/30/1996	3,247	324	10	324		1,730	8
9	Enlarge parking	9/3/2002	2,386	119	20	119		236	9
10	Drainage culvert	3/28/2003	1,419	79	18	79		150	10
11	Dumpster fence	6/24/2003	769	77	10	77		143	11
12	Fully Depreciated Draperies	4/23/1990	7,204		5			7,204	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	Less: Disposals		(225,166)					(130,352)	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,974,396	$ 146,134		$ 154,772	$ 8,638	$ 2,213,717	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 295,040	$ 33,743	$ 33,743	$	Various	$ 171,229	71
72	Current Year Purchases	56,807	4,065	4,065		Various	4,065	72
73	Fully Depreciated Assets	354,055				Various	354,055	73
74	Home Office Allocation	113,088	15,059	15,059			51,085	74
75	TOTALS	$ 818,990	$ 52,867	$ 52,867	$		$ 580,434	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Van	1992	$ 14,250	$	$	$	8	$ 14,250	76
77	Patient Transportation	New Motor	2000	3,323				3	3,323	77
78										78
79	Home Office Allocation			13,724	3,343	3,343			8,368	79
80	TOTALS			$ 31,297	$ 3,343	$ 3,343	$		$ 25,941	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,904,700	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 202,344	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,982	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,638	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,820,092	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 10,800	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 10,800	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 11,448	92
93			93
94			94
95		$ 11,448	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 856,220	$	1
2	Cash-Patient Deposits	13,005		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 53,120)	514,368		3
4	Supply Inventory (priced at FIFO)	7,678		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Acc Int Rec & Other A/R	1,432		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,392,703	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	81,971		13
14	Buildings, at Historical Cost	3,754,969		14
15	Leasehold Improvements, at Historical Cost	141,850		15
16	Equipment, at Historical Cost	730,671		16
17	Accumulated Depreciation (book methods)	(2,726,374)		17
18	Deferred Charges	18,404		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	199,338		21
22	Other Long-Term Assets (spe CIP	11,448		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,212,277	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,604,980	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 179,563	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,005		28
29	Short-Term Notes Payable	35		29
30	Accrued Salaries Payable	189,500		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	166		32
33	Accrued Interest Payable	12,133		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 394,402	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,373,875		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Annuity Payable	111,447		43
44	Revolving Loan Payable	84,281		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,569,603	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,964,005	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,359,025)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,604,980	$	48

***(See instructions.)**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,898,035)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,898,035)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	442,010	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 442,010	17
	B. Transfers (Itemize):		
18	**Transfer in from Affiliate**	97,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 97,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,359,025)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,290,376	1
2	Discounts and Allowances for all Levels	(786,921)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,503,455	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	741,228	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 741,228	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23,770	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,930	19
20	Radiology and X-Ray	26,823	20
21	Other Medical Services	5,987	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 82,510	23
	D. Non-Operating Revenue		
24	Contributions	31,119	24
25	Interest and Other Investment Income***	8,348	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 39,467	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Investment/Equip Disposal	(4,166)	28
28a	Actuarial Gain(Loss)	4,558	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 392	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,367,052	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	938,126	31
32	Health Care	2,779,281	32
33	General Administration	1,396,191	33
	B. Capital Expense		
34	Ownership	674,124	34
	C. Ancillary Expense		
35	Special Cost Centers	50,028	35
36	Provider Participation Fee	87,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,925,042	40
41	**Income before Income Taxes (line 30 minus line 40)****	442,010	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 442,010	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,665	1,829	$ 54,924	$ 30.03	1
2	Assistant Director of Nursing	1,763	1,888	41,422	21.94	2
3	Registered Nurses	9,053	9,729	231,288	23.77	3
4	Licensed Practical Nurses	30,885	32,046	439,732	13.72	4
5	Nurse Aides & Orderlies	108,484	112,794	1,089,124	9.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,169	3,302	31,810	9.63	8
9	Activity Director	1,785	1,796	18,610	10.36	9
10	Activity Assistants	990	995	9,222	9.27	10
11	Social Service Workers	8,907	8,969	109,373	12.19	11
12	Dietician					12
13	Food Service Supervisor	1,821	1,900	28,734	15.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,122	22,652	198,418	8.76	15
16	Dishwashers					16
17	Maintenance Workers	3,855	3,886	44,000	11.32	17
18	Housekeepers	21,001	21,168	216,990	10.25	18
19	Laundry					19
20	Administrator	1,614	1,884	82,548	43.82	20
21	Assistant Administrator					21
22	Other Administrative	1,771	1,870	30,733	16.43	22
23	Office Manager	1,785	1,906	36,691	19.25	23
24	Clerical	1,769	1,830	17,838	9.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,639	1,643	20,606	12.54	33
34	TOTAL (lines 1 - 33)	224,078	232,087	$ 2,702,063 *	$ 11.64	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	302	$ 12,705	1.3	35
36	Medical Director	18	5,500	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	216	1,200	10.3	39
40	Physical Therapy Consultant	3,522	213,487	10A.3	40
41	Occupational Therapy Consultant	2,807	157,359	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	708	51,078	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	88	5,088	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,661	$ 446,417		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James E. Burrell	Administrator	0	$ 82,548
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,548

B. Administrative - Other

Description	Amount
Management Expense	$ 323,664
TOTAL (agree to Schedule V, line 17, col. 3)	$ 323,664
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 5,898
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 5,898

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,072
Unemployment Compensation Insurance	6,000
FICA Taxes	193,098
Employee Health Insurance	225,600
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	15,682
Employee Physicals	2,111
Employee Uniforms	648
Home Office Allocation	33,452
TOTAL (agree to Schedule V, line 22, col.8)	$ 572,663

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,652
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	7,175
Remote & Online Fees	251
Software Support	6,078
Dues & Subscriptions	1,663
Miscellaneous	353
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,172

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,635
Miscellaneous	30
Seminar Expense	3,934
Home Office Allocation	14,029
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,627

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Shawnee Christian Nursing Center **#** 0025619 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $ 7175**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,041** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,292**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Shawnee Christian Nursing Center | | sms
Summary of Payroll Expenses | 6/30/2004 | 11/3/2005

Payroll Tax	Unemploy Contrib	Workers Comp	Health Ins	W.C. Medical Exp	Employee Uniforms	Employee Benefits	Employee Expense	Physicals	Totals	
8,260.16	192.00	3,144.00	14,400.00		648.23		15,682.06	2,110.50	44,436.95	
804.23	96.00	1,572.00	4,800.00						7,272.23	
16,754.68	612.00	9,732.00	10,800.00						37,898.68	
18,499.03	540.00	8,628.00	18,400.00						46,067.03	
139,197.26	4,200.00	67,140.00	159,200.00						369,737.26	
8,330.80	324.00	5,220.00	13,200.00						27,074.80	
1,252.22	36.00	636.00	4,800.00						6,724.22	
									0.00	539,211.17
193,098.38	6,000.00	96,072.00	225,600.00	0.00	648.23	0.00	15,682.06	2,110.50	539,211.17	

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Shawnee Christian Nursing Center
Staffiing and Salary Costs

sms
06/30/04 11/03/05

Description	Line Number	Salary	% of Benefits	Benefits	Total Salary
Director of Nursing	20.1	53,046.42	2.91%	1,877.43	54,923.85
Assist. DON	20.2	40,005.80	2.19%	1,415.89	41,421.69
Registered Nurses	20.3	223,382.32	12.25%	7,905.97	231,288.29
Licensed Practical Nurses	20.4	424,701.16	23.29%	15,031.07	439,732.23
Nurses Aides & Orderlies	20.5	1,051,895.66	57.68%	37,228.82	1,089,124.48
Rehab/Therapy Aides	20.8	30,722.38	1.68%	1,087.33	31,809.71
	Total	1,823,753.74	100.00%	64,546.51	1,888,300.25

Benefits		64,546.51					
	20.1	20.2	20.3	20.4	20.5	20.8
	53,046.42	40,005.80	183,730.87	15,227.27	32,311.70	30,722.38
			14,876.60	177,566.23	31,880.46	
			20,057.20	202,216.81	23,851.98	
			415.47	29,690.85	454,842.20	
			4,302.18		386,481.30	
					14,600.93	
					36,565.31	
					66,570.93	
					1,074.74	
					3,716.11	
Totals	53,046.42	40,005.80	223,382.32	424,701.16	1,051,895.66	30,722.38

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